

Ticket #: \_\_\_\_\_ Request Date: \_\_\_\_\_ Request Time: \_\_\_\_\_

### PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of Zykadia® ceritinib. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

| A. Member Information  |  |                        |                          |
|--|--|------------------------|--------------------------|
| Patient Name:  |  | Plan Name/Plan ID:     |                          |
| Patient ID:  |  | Patient Date of Birth: | Patient Contact Phone #: |
| B. Physician Information   |  |                        |                          |
| Physician Name:  |  | Physician Address:     |                          |
| Physician DEA #:   | Physician Phone #:   | Physician Fax #:       |                          |
| Drug Name and Strength:  | Direction (SIG):   | QTY and Days Supply:   | NDC #:                   |
| C. Pharmacy Information  |  |                        |                          |
| Pharmacy Name:   | NABP #:  | Pharmacy Phone #:      | Pharmacy Fax #:          |
| D. Clinical Information (Please fill out the following information: circle all that apply) |  |                        |                          |
| 1.   | Does this patient have the diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC)? | YES                    | NO                       |
| 2.   | Has the patient progressed on or proved to be intolerant to crizotinib?  | YES                    | NO                       |
| 3.   | Is the prescribing physician and oncologist?   | YES                    | NO                       |
| Authorized Medical Signature:  |  |                        |                          |
| Telephone:   |  | Date:                  |                          |

**When Completed Return To:**

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507  
 1-866-965-Drug (3784) / Fax # 866-999-7736

\*\*Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.

Prior authorization forms are reviewed at least annually and are available at [www.procarerx.com](http://www.procarerx.com). Medical Review Criteria are reviewed at least annually. Revised 09/2015